STATE MEDICARE BUY-IN PROBLEM REPORT

(Please complete form with blue ink only)

Please check the three-digit MEDS Medicare status line before submitting a State Medicare Buy-in Problem Report. The first digit code indicates the status of Medicare "Part A" coverage. The second digit code indicates the status of Medicare "Part B" coverage. The third digit code indicates the status of Medicare "Part D." The codes and there definitions are as follows:

The MEDICARE PART A AND MEDICARE PART B CODE

0 or **BLANK** No coverage
1 = Paid by beneficiary
2 = Paid by State
3 = Free Part A
4= Paid by state other than California
5= Paid for by Pension Fund
7= Presumed eligible
9= Aged alien ineligible for Medicare

THE MEDICARE PART D CODES

0 or **BLANK** No Coverage
1= Approved Low Income Subsidy Status
2= Beneficiary is eligible for Part D
3= Beneficiary deemed Low Income Subsidy eligible
7= Presumed eligible
9= Beneficiary has refused Part D

Note: The State Medicare Buy-in Problem Report is available on the Electronic Mail Communication Center (EMC2 or E-Mail) and may be submitted electronically.

A. COUNTY REPRESENTATIVE INFORMATION

Name (First, Last)			County district
County mailing address			E/W number
City	State	Zip Code	Date submitted
Telephone number			Response Requested ☐ Yes ☐ No

B. BENEFICIARY INFORMATION

Name (First, Middle, Last)		
Client Identification # (CIN #)	Medicare/railroad claim (HIC) number	
Date of birth (month/day/year)	Sex ☐ Male ☐ Female	
Special Program ☐ Medi-Cal ☐ QMB ☐ SLMB ☐ Other QI-1_____		

C. PROGRAM ELIGIBILITY/CASE IDENTIFICATION

County	Aid	7-Digit Serial Number	FBU	Person Number	Eligibility Date	Approval Date

Remarks—Explain Buy-In Problem Check if any documents attached Attachments ☐

D. STATE USE ONLY

☐ Medicare claim number (HIC) is incorrect. The correct HIC number is:_____
☐ Accretion confirmed ..... ☐ Part A ☐ Part B Effective date: _____
☐ Deletion confirmed ..... ☐ Part A ☐ Part B Effective date: _____
☐ Closed period confirmed ..... ☐ Part A ☐ Part B Effective date: _____ through: _____
☐ Part A ☐ Part B Benefits terminated effective
☐ Medi-Cal card corrected to remove Medicare indicator 1, 2, 3.
☐ Accretion not possible due to:_____
☐ Medi-Cal ☐ QMB ☐ SLMB ☐ _____eligibility on MEDS not being reported currently.
☐ QMB beneficiary is not currently enrolled for Part A benefits. Refer beneficiary to SSA and apply during general/open enrollment Period (January through March; effective in July).
☐ Medi-Cal and/or QMB beneficiary is not currently enrolled for Part B benefits. Have beneficiary go to SSA and apply.
☐ Part A benefits terminated effective:_____. ☐ Part B benefits terminated effective: _____
☐ Out-of-state Buy-In status reflecting out-of-state code. Please update MEDS to show current effective date for Medi-Cal.
☐ Aid code _____ requires two-month Medi-Cal eligibility before the state Buy-In coverage will begin.
☐ Beneficiaries with Aid code _____ are not eligible for Buy-In.
☐ Please allow 120 days for processing.

Remarks

Medicare Premium Payment representative	Telephone number ( )	Date

INSTRUCTIONS FOR COMPLETION OF DHS 6166

The State of California, under Section 10850 of the Welfare and Institutions Code, requests this information in order to resolve complaints and problems received regarding the state payment of Medicare premiums. Completion of the form is voluntary and the consequences for not providing the information will result in unresolved problems and, potentially, no state payment of premiums. The information will be provided to the California Department of Health Care Services, Health Insurance Premium Payment Unit.

A. COUNTY REPRESENTATIVE IDENTIFICATION

- Eligibility worker's name
- Complete mailing address *(response will not be returned without this information)*
- Area code and telephone number
- County district number
- Eligibility worker number
- Date submitted
- Check to indicate whether a state response is requested for this complaint

B. BENEFICIARY IDENTIFICATION

- Complete name, include any AKAs
- Client Identification Number
- Medicare/Railroad Health Insurance Claim (HIC) number
- Date of birth using mm/dd/yy format
- Sex
- Check appropriate special program

C. PROGRAM ELIGIBILITY/CASE IDENTIFICATION

- County code
- Aid code
- Seven-digit serial number
- FBU
- Medi-Cal person number
- Eligibility date (for Medi-Cal including retroactive months of entitlement)
- Approval date (for Buy-In, determination can be no earlier than month of application and may be later).

  For example:
  1. Applied for Medi-Cal..... April 1993
  2. Approval date ..... May 1993
  3. Medi-Cal effective date ..... January 1993
  4. Buy-In effective date: ..... July 1993

- Remarks – provide an explanation of the Buy-In problem.
- Check if any documents are attached.

D. STATE USE ONLY

Medicare Premium Payment's response, if requested in Section A, above. **Mail to:**

Department of Health Care Services
Third Party Liability and Recovery Division
Medicare Operations Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422